SAMHSA-HRSA
Center for Integrated Health Solutions

Opportunities to Enhance Behavioral Health/Primary Care Integration and the Health Care Safety Net

Arizona Integration Forum

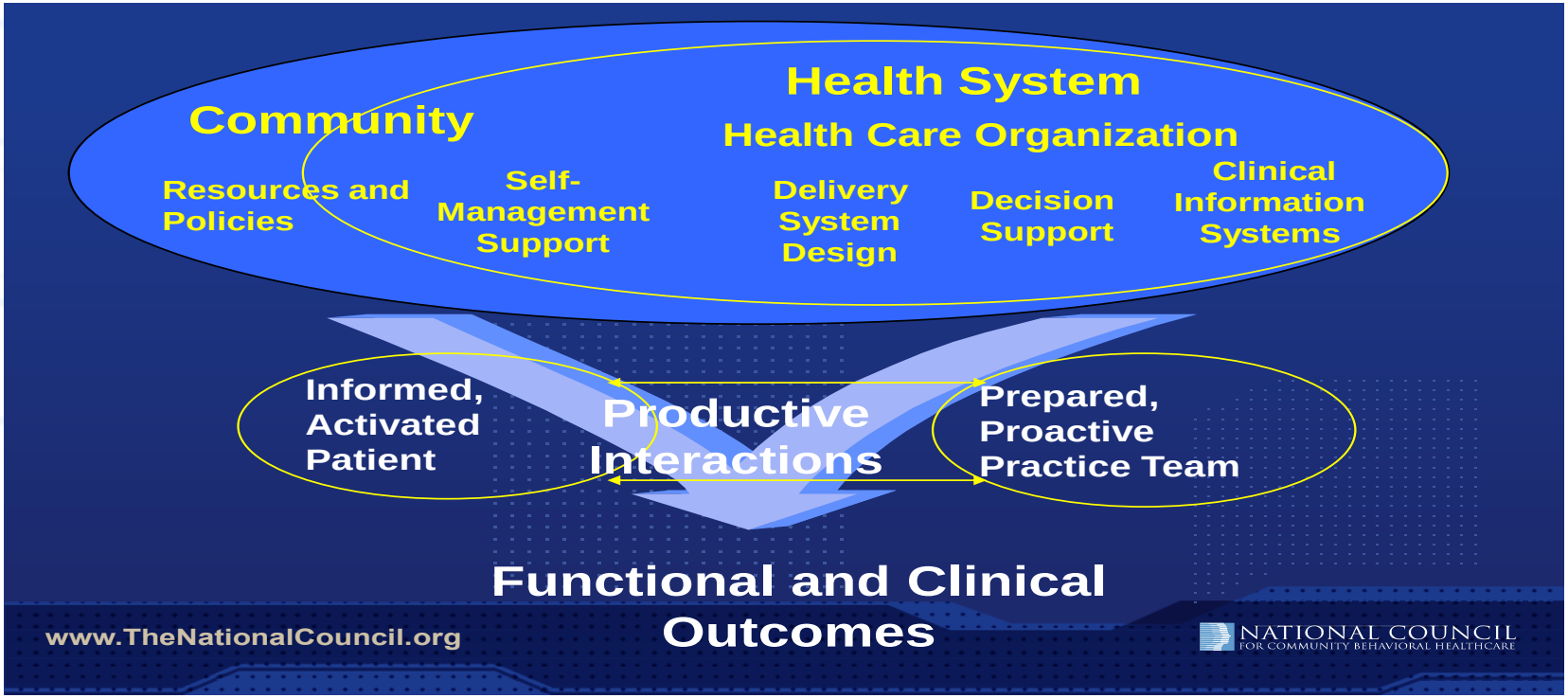
January 26, 2011

Presentation Overview

- Conceptual Models of Integration
- Clinical Delivery Systems
- Business Models
- Advantages of Partnerships
- Return on Investment
- Resources

Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On-Site	Close Collaboration/ Partly Integrated	Fully Integrated/Merged
THE CONSUMER and STAFF PERSPECTIVE/EXPERIENCE					
Access	Two front doors; consumers go to separate sites and organizations for services	Two front doors; cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
Services	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for Q4 consumers	Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;	Q1 and Q3 one physician prescribing, with consultation; Q2 & 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers	One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one physician prescribing for Q1, 2, 3, and some 4; two physicians for some Q4: one set of lab work
Funding	Separate systems and funding sources, no sharing of resources	Separate funding systems; both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility
Governance	Separate systems with little of no collaboration; consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases	Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4	Two governing Boards that meet together periodically to discuss mutual issues	One Board with equal representation from each partner
EBP	Individual EBP's implemented in each system;	Two providers, some sharing of information but responsibility for care cited in one clinic or the other	Some sharing of EBP's around high utilizers (Q4) ; some sharing of knowledge across disciplines	Sharing of EBP's across systems; joint monitoring of health conditions for more quadrants	EBP's like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants
Data	Separate systems, often paper based, little if any sharing of data	Separate data sets, some discussion with each other of what data shares	Separate data sets; some collaboration on individual cases	Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups	Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source

Wagner Chronic Care Model



National Council

4 Quadrant Model

The Four Quadrant Clinical Integration Model

*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment

- **Quadrant I: Low BH/Low PH**
  - PCP (with standard screening tools and BH practice guidelines)
  - PCP- Based BH

- Interventions
  - Screening for BH Issues (Annually)
  - Age Specific Prevention Activities
  - Psychiatric Consultation
- Financing
  - Primary Care Visits
  - SBIRT Codes for Substance Abuse

- **Quadrant II – High BH/Low PH**
  - BH Case Manager w/responsibility for coordination w/PCP
  - PCP with tools
  - Specialty BH
  - Residential BH
  - Crisis/ER
  - Behavioral Health IP
  - Other Community Supports

- **BH Interventions in Primary Care**
  - **IMPACT Model for Depression**
  - **MacArthur Foundation Model**
  - **Behavioral Health Consultation Model**
  - **Case Manager in PC**
  - **Psychiatric Consultation**
- **PC Interventions CMH**
  - **NASMHPD Measures**
  - **Wellness Programs**
  - **Nurse Practitioner, Physician's Assistant, Physician in BH**
- **Financing**
  - Disease Management Pilot in Michigan
  - CMH Capitation
  - Two BH visits a month in primary care

- **Quadrant III – Low BH/High PH**
  - PCP with screening tools
  - Care/Disease Management
  - Specialty Med/Surg
  - PCP based- BH
  - ER

- **Interventions**
  - BH Ancillary to Medical Diagnosis
  - Group Disease Management
  - Psychiatric Consultation In PC
  - MSW in Primary Care
  - BH Registries in PC (Depression, Bipolar)
- **Financing**
  - 96000 Series of Health and Behavioral Assessment Codes
  - Two BH Visits a month are billable

- **Quadrant IV- High BH/High PH**
  - PCP with screening tools
  - BH Case Manager with Coordination with Care Management and Disease Management
  - Specialty BH/PH

- **Interventions in Primary Care**
  - **Psychiatric Consultation**
  - **MSW in Primary Care**
  - **Case Management**
  - **Care Coordination**
- **Interventions in BH**
  - **Registries for Major PC Issues (Diabetes, COPD, Cardiac Care)**
  - **NASMPD Disease Measures**
  - **NP, PA or Physician in BH**
- **Financing**
  - **BH Capitation**
  - **Primary Care Visits**

Clinical Delivery Models

- Behavioral Health Consultant model - Doctorate level psychologists providing brief interventions in the exam room
- Advanced Nurse Practitioners, Physician's Assistants or Medical Doctors in CMH
- Bi-directional integration – both models
  - Social workers, licensed professional counselors
  - Bachelor level staff –Case management

Key Concepts Across Successful Models

- Warm Handoffs vs. referrals
- Consulting Psychiatrist vs. extended evaluation with case load
- Primary Care Provider Prescribing vs. two prescribers
- Care/Case Manager vs. consumer only
- Recovery/Self Management Skills
- Shared documentation

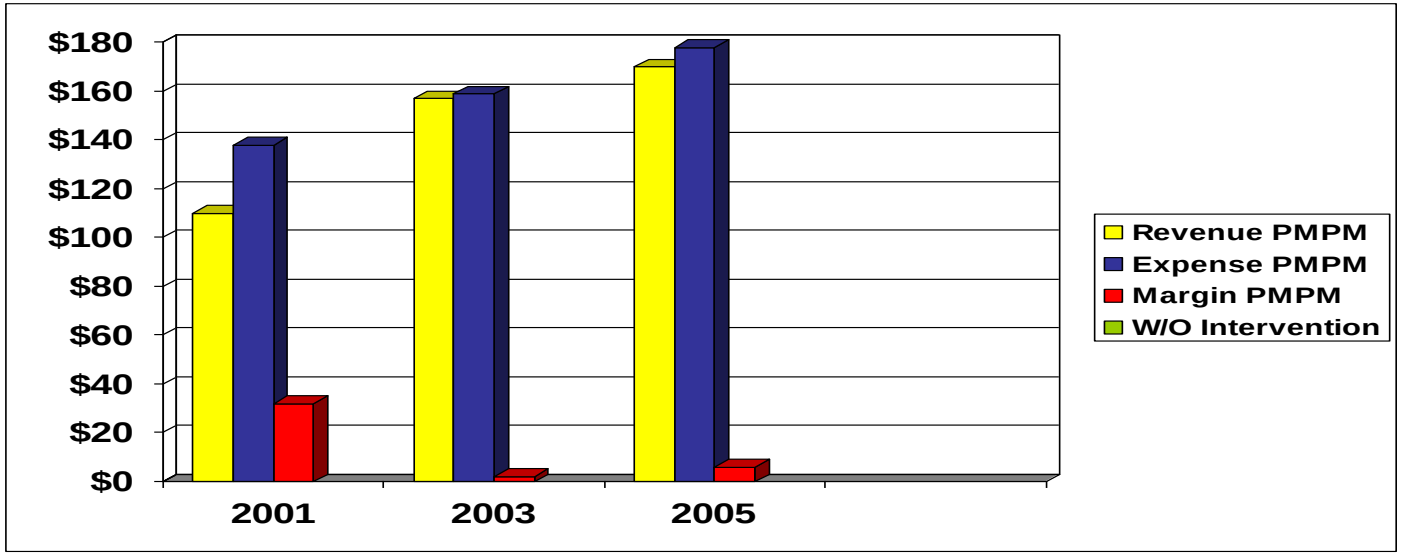
Business Models

- Partnership Models
  - Safety Net Provider Partnerships (Federally Qualified Health Centers + Community Behavioral Health Organization)
  - Public/Private Partnerships
- Organization becomes an FQHC and a CBHO
- One organization does both without the public designations

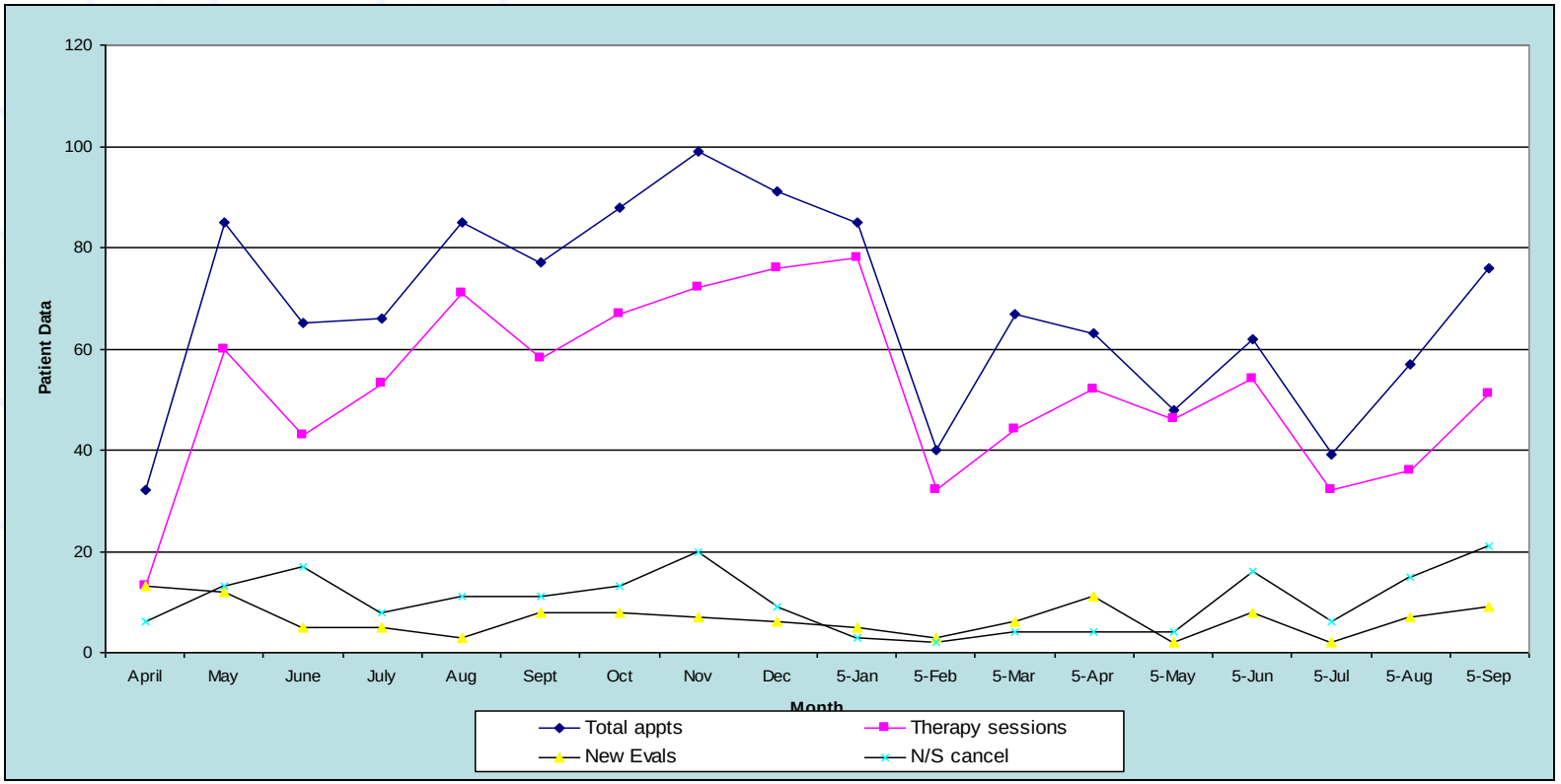
Advantages of Partnerships

- Strengths based approach – capitalizes on both organizations strengths
- Financing benefits
  - Case Management (CMHC)
  - Encounter billing (FQHC)
  - Works now!
- Respects history of the organizations/community
- Impact on stigma

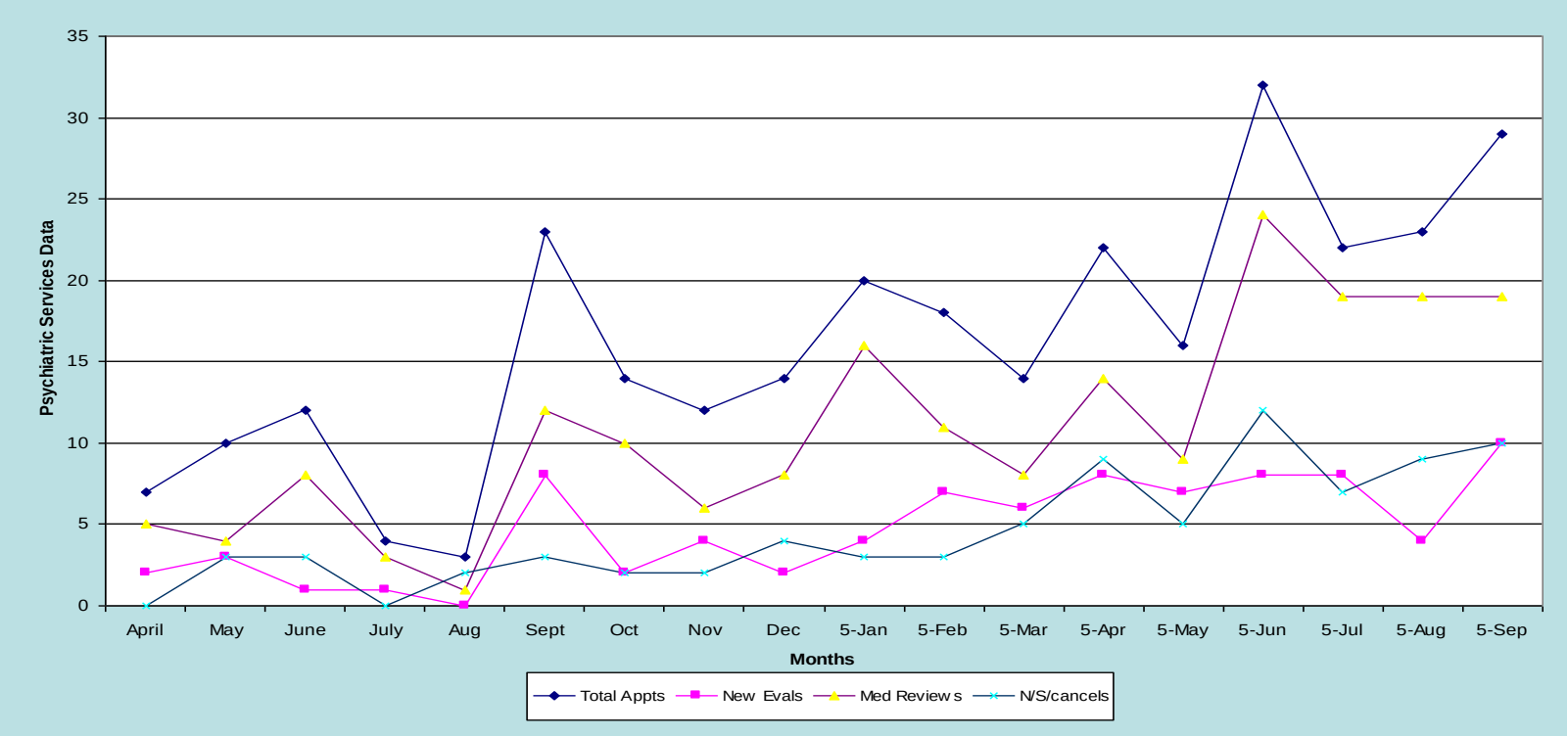
Impact on Costs



MSW Visit Rate – No Shows When Provided In Primary Care



Psychiatrists – No Show Rates In Primary Care



Resource – Center for Integrated Health Solutions

- Funded by SAMHSA/HRSA
- $5.3 Million grant for four years
- Target Populations
  - SAMHSA Grantees
  - HRSA Grantees
  - General Public
- Services
  - Training and Technical Assistance
  - Knowledge Development
  - Prevention and Wellness
  - Workforce Development
  - Health Reform Monitoring and Updates

Kathleen Reynolds LMSW, ACSW
kathyr@thenationalcouncil.org

www.thenationalcouncil.org – Center of Integration Health Solutions Resource Center

Learning Communities